Arizona Health Care
Cost Containment System
Issue Paper on High-Risk Pools

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I. INTRODUCTION – WHAT ARE HIGH-RISK POOLS?

High-risk pools are government-run health insurance programs for people who have been identified as "uninsurable" by private individual insurers. Since 1976, many states have experimented with high-risk pools as a way to make coverage available to people with actual or expected high health care costs, while keeping insurance affordable for the rest of the private market. Generally, high-risk pools are open to people who have been denied coverage by one or more insurance companies or were only offered coverage at either a very high substandard premium or with significant coverage limits.

Currently, 29 states have created some form of special state health insurance program to guarantee access for the uninsurable population. The uninsurable population are generally individuals with pre-existing conditions and/or chronic conditions which cause them to be denied standard coverage. High-risk pools typically cost more than standard insurance coverage, but generally have a cap on the amount of premium that can be charged. The cost of the high-risk pool is generally higher than the premium that is charged to the pool participants, since the participants are known to have major health problems leading to high cost health services. As a result, risk pools need subsidies in the form of assessments to the insurance industry, contributions from providers or through some other state funding mechanisms in order to fully fund the program.

Risk pools provide some stability to the insurance market. However, many people who could benefit from these programs don't know they exist. Since states try to keep costs down, little, if any, marketing is done. Some states require that individuals who are rejected by health insurance carriers be notified about the high-risk pool.

Risk pools are typically a temporary stopping point for many individuals. Many people enroll for only a limited time and then drop out when they become eligible for coverage elsewhere. Some may leave the program when they find a company that will accept them at a lower rate while others may obtain coverage through a new employer sponsored plan. The average time an individual spends in a risk pool is 30 months.

II. EXECUTIVE SUMMARY

High-risk pools can be a very important mechanism in today's health care environment. They basically serve two important roles:

- They can help to reduce the number of uninsured individuals by guaranteeing everyone in the state, specifically relatively high cost/uninsurable individuals, access to "affordable" quality health care. "Affordable" means affordable relative to the insurance risk (or expected costs) of the individual, although they may still have to pay a fairly high premium.

- Some studies imply that they can help to keep the commercial premium rates low and entice lower cost individuals to purchase insurance and keep the individual insurance market competitive. High-risk pools can provide stability to the health insurance system when they are well conceived.

The funding of the program is the most crucial element in the development of a successful program. Since the cost per individual for these programs is significantly more than that of the standard insurance market, the costs must be funded by more than just enrollee premiums. The more parties that are involved in funding the program, the more the costs are spread out, thus easing the financial burden for all. Two of the more successful programs are those in Minnesota and Wisconsin. In Minnesota the financial burden is funded by three different sources – enrollee premiums, insurer assessments, and state appropriations while in Wisconsin, the financial burden is funded by four different sources – enrollee premiums, insurer assessments, provider contributions and state appropriations. Each state also has a fairly low uninsured percentage – 10% and 13%, respectively.

Another important element in the design of a high-risk pool is a premium rate cap for the plan. The lower the premium rate cap, the greater the number of individuals that will be eligible for and be able to afford the plan. As the enrollment increases, the funding is of greater importance, especially in high inflationary times. The higher the enrollment, the greater the strain on all funding parties involved (especially if any state funding does not keep pace with inflation and enrollment increases).

High-risk pool coverage is typically a comprehensive health insurance plan with deductibles and coinsurance similar to that found in the commercial market. These programs are not typically designed for low income "chronically ill individuals" (other programs such as Medicaid target this population) but are rather for "chronically ill individuals" who do not have employer sponsored plans, are self-employed or are unemployed.

This paper was developed for the Arizona Health Care Cost Containment System as part of the Arizona State Planning Grant, which is funded by the Health Resources Services Administration. It provides summary information about high-risk pools. A more detailed analysis of this subject was beyond the scope of this paper, but should be completed before designing or implementing a high risk pool. This paper assumes that the reader is familiar with the design of health insurance plans and the health care system in the United States. It should only be reviewed in its entirety.

III. SUMMARY OF CURRENT STATE HIGH-RISK POOLS

Eligibility

Each state offering a high-risk pool has established rules regarding who is eligible to be covered under the program. Eligibility varies by state, however, the most common eligibility requirements are as follows:

State Residency – Individuals applying for the plan must typically provide proof that they are a current resident of the state. Residency requirements range from 30 days up to one year before they become eligible.

No Other Health Coverage – An eligible individual is one who does not have other health insurance coverage. However, states do not typically require a period without insurance before becoming eligible for the program.

Rejection or Exclusion – Many plans require proof that an individual has been rejected (or terminated for reasons other than non-payment of premiums) for health insurance by one or more carriers within the last six to twelve months. Also, if an individual is accepted by a carrier, but acceptance is contingent on a reduced benefit or exclusion of stated pre-existing conditions, the individual may be eligible for the state's high-risk pool. No state restricts coverage to a specified list of medical conditions.

Rate Increase or Rate-Up – If an individual has insurance coverage but has received a rate increase that results in rates higher than the pool's rates (varies by state), the individual may qualify for the state's high-risk pool. Also, if an individual is accepted by a carrier, but acceptance is based on a substandard rate-up that results in a rate higher than the pool's rate, the individual may qualify for the state's high-risk pool.

Enrollment Caps – Some states limit the number of insureds covered. In the event that an individual qualifies for coverage and the enrollment is at the state's limit, the individual will be placed on a waiting list. As individuals lapse, those on the waiting list will be allowed coverage. Enrollment in risk-pools has been growing over the last few years and consists of approximately 110,000 members nationwide as of early 2000.

HIPAA Portability – As a result of HIPAA, individuals who have been insured and have lost coverage for various uncontrollable reasons are eligible under HIPAA's portability rules.

If an individual terminates coverage from the program, generally the individual is not eligible to re-enroll until at least twelve months have elapsed since termination. Appendix A shows the current participants for the various state high-risk pools along with the number of uninsured and percentage of uninsured by state.

Types of Plans

Many states offer more than one type of plan, such as: Indemnity, PPO or HMO. Nearly all states offer coverage with an upfront deductible, then coinsurance with an out-of-pocket maximum (see Benefit Design discussion below). The coinsurance percentage varies by state. Under an indemnity type plan, there are no restrictions on the provider of care and the plan has a fixed coinsurance percentage. For those states that have a PPO plan, the coinsurance varies by in-network versus out-of-network usage. In general, if a state has a network of providers, the plan will pay a higher coinsurance percentage if the individual utilizes the network since the pool probably gets some form of discount from the network providers. A higher percentage coinsurance helps incent individuals to use the network (since they will have to pay less out-of-pocket) and attempts to reduce the overall cost of the program. At least one state (Wisconsin) offers an indemnity type plan but requires individuals to use Medicaid certified providers.

Several states also offer a Medicare Supplement plan. The types of plans vary by state with some states offering coverage to any Medicare eligible individual (who also meets pool criteria) while other states only offer coverage to Medicare disabled individuals.

All states with risk pools offer a comprehensive benefits package which cover inpatient, outpatient, and physician services. Nearly all states cover mental health/substance abuse treatment, but a majority have either day limits or dollar limits on these benefits. Dental and vision care benefits are included in only a few pools.

Benefit Design

The benefit design of high-risk pools varies significantly from state to state. The following are the various provisions included in the plans:

Deductibles – Deductibles that the insured must pay range from $250 - $10,000 with a majority of the states offering a $500 or $1,000 deductible. California is the only state that does not use a deductible but instead has a $25 office visit copay. Some

states have subsidy programs for lower income individuals that will help pay for a portion of the individual's deductible.

Coinsurance – The predominant coinsurance percentage used is 80%/20% (80% of the expense is paid by the pool after the individual satisfies the deductible). However, coinsurance percentages may vary depending on where the service is performed. When PPO plans are offered, the coinsurance generally varies with a lower coinsurance amount paid for out-of-network services. In most instances, PPO type plans have negotiated discounts with network providers and therefore offer a richer coinsurance benefit in-network in order to entice individuals to use the network. By using the network, the plan can reduce the cost as a result of the discounts, as well as reduce utilization due to managed care.

Annual Out-of-Pocket Maximums – Most states have an out-of-pocket coinsurance maximum that limits the amount the insured must pay each year. The out-of-pocket is the maximum the individual is responsible to pay for coinsurance only with a total out-of-pocket equal to the sum of the deductible and the coinsurance limit. Once the individual has reached the coinsurance limit, the plan covers 100% of the cost up to any annual or lifetime benefit maximum. Out-of-pocket limits range from $1,000 to unlimited, with the majority ranging from $1,000 to $5,000.

Lifetime Benefit Limit – Approximately half of all the states have a maximum lifetime benefit limit of $1,000,000 and approximately one-quarter have a lifetime limit of $500,000. Other lifetime limits range from $350,000 to unlimited.

Pre-existing Conditions – Most plans contain a provision that excludes coverage for a certain period of time (waiting period) following the effective date of coverage for new enrollees. The pre-existing condition exclusion is meant to reduce adverse selection against the plan by preventing individuals from waiting until they know that they need care before applying for coverage. The exclusion is based on a pre-existing condition that manifested itself within a certain period of time (condition period) prior to coverage which ranges from none to six months. The waiting periods range from no wait up to 12 months. Approximately half of the plans in existence currently have a six month waiting period and six month condition period.

However, there is one exception to the pre-existing condition requirement. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates that people going from group coverage to individual coverage, can have guaranteed insurability in all states. Also, due to HIPAA legislation, HIPAA eligibles are not only guaranteed access but they are not required to satisfy any waiting period before coverage begins.

Program Financing

Due to the high cost nature of high-risk pools, more than one funding source is generally needed to cover the operating and administrative expenses of the plan. Various funding mechanisms have evolved over the past several years. The following are mechanisms currently being used or considered in risk pools today.

1) Policyholder Premiums – Policyholder premiums are collected by all high-risk pools. In general, premiums collected from enrollees cover approximately 50% of the cost to operate the plan, however, percentages vary by state. Nearly all states have a maximum premium amount that policyholders are required to pay. The maximum is usually based on a percentage of the average premium that can be obtained in the private individual health market in the state. For those states that have a premium cap, the cap ranges from a low of 125% to a high of 250%. Two states (KS and UT) do not have a cap and the premiums attempt to be self-supporting after some state subsidy money is applied.

   The average industry rates are generally based on rates that can be obtained in the private individual health market, adjusted to the high-risk pool's benefit structure. Average industry rates vary by age, gender and benefit plan (most states have multiple benefit plans).

2) State Subsidies – There are various ways in which states can subsidize the cost of the pool. Some states use general tax revenue that is appropriated to the plan each year. Pool costs are therefore spread over all taxpayers. The amount can vary each year and is not generally linked to program costs.

   Another indirect way is allowing tax credits on insurer assessments. Assessments are offset against premium taxes or income taxes paid to the state so the state ultimately is responsible for the funding revenue.

   Several states also provide subsidies for low-income individuals in the way of lower premiums and deductibles. The amount of the subsidies can vary by plan and income level. In some states, the reduced premium and deductible subsidies may be funded by any combination of state subsidies, insurer assessments and provider contributions.

3) Insurer Assessments – This option is being used by a majority of the states. Generally, the total cost of the program is estimated for the plan year, with a portion of the cost being allocated to the insurers doing business in the state. The insurers' portion is allocated to each individual carrier based on their health insurance premium volume written in the state. In effect, the insurance carriers are being assessed for the policyholders they would normally turn down for coverage based on their underwriting standards. Due to ERISA, self-insured plans are exempt from assessments.

   Another form of insurer assessment is one that places a monthly fee on health insurance carriers within the state according to how many policyholders or certificates they cover. Under this form of assessment, insurers can easily predict what their assessment will be and the pool will know what to expect in revenue.

4) Provider Contributions – This option is currently being used by only two states (Minnesota and Wisconsin). Minnesota assesses a 1.5% tax on hospital and provider charges in the state. Because self-insured employers must pay healthcare providers, they now indirectly contribute to the funding. In contrast, Wisconsin's pool reimburses providers a lower amount than what they normally receive based on usual and customary charges. The difference between the amount paid to providers (allowed amount) and the usual and customary charges is in essence the amount the providers contribute to the plan funding.

5) Other Options – Some states are either using or considering using funds from tobacco settlements, taxes on alcohol and tobacco products, state lottery proceeds or a fee on all income tax paying individuals.

Program Administration

High-risk pool programs are generally run by a designated state agency. A Board of Directors oversees the program operations. The State and the Board usually work in conjunction to set budgets, suggest changes to administrative rules, set rates, etc. The State generally contracts with a third party administrator to perform the day-to-day operations of the plan. The administrative costs are low compared to commercial plan expenses and generally range from 5% - 10% of total paid claims.

How Well are High-Risk Pools Working?

Most individuals covered by the pool believe that high-risk pools work well because they are able to obtain health insurance coverage at a somewhat reasonable rate, while without them, many are uninsurable. On the other hand, insurers that are responsible for a portion of the funding may think that the pools are not such a good idea. With increasing enrollments, insurers are seeing their assessments increase beyond what they believe they can afford to pay (although their policyholders should ultimately pay for the assessments).

Therefore, how well high-risk pools are working depends in large part on your point of view. The overall health of the programs vary considerably from state to state and the mechanisms by which they are funded.

In general, high-risk pools in states that are well funded appear to work well in providing consumers who have health problems with affordable quality insurance and at the same time are financially sound. However, risk pools in states that are not well funded have not worked as well, resulting in some states raising premiums or reducing benefits. Some states have also closed their pools to new enrollees or have implemented enrollment caps to keep costs at a tolerable level. A well funded pool may require sources of income in addition to premiums and insurer assessments.

The highest cost uninsurable individuals will generally be the first ones to join a high-risk pool. As program enrollment grows, the cost per individual is expected to decrease since there are high risk individuals with chronic conditions who are not presently high cost. However, an increasing number of individuals will increase the total cost of the pool due to higher enrollment, thus increasing the total cost not covered by premiums.

Attached in Appendix B are brief summaries of how various state high-risk pools are set up.

IV. IMPACT ON INSURANCE MARKET

Based on various studies of high-risk pools, it appears that when high risk pools provide reasonably comprehensive coverage, are reasonably subsidized, and are not limited by enrollment caps, the individual health insurance market seems to work better. Some believe this result to be because when insurers are confident that the high cost or uninsurable people have access to high-risk pools, they are less fearful of the adverse selection risk that can come from high-risk individuals. Insurers can offer lower premiums which entice more lower risk individuals to purchase individual health insurance. As a result, insurers feel there is a much lower financial risk to their companies since a large number of high cost individuals are removed from the market.

In the absence of high-risk pools, the high-risk or uninsurable individuals may still get care, but it is often uncompensated or under-compensated care. Everyone ultimately subsidizes their care through either tax dollars that go directly to public facilities that provide the care or through implicit surcharges that are added by providers and thus impact private health insurance premiums. In this situation, the patients may delay care too long, receive the care in an inappropriate setting and believe the quality of care to be compromised.

High-risk pools that do not have enrollment caps basically guarantee insurability to all members of the state regardless of whether they are relatively high cost or even uninsurable. With premium rate caps being used in many of the states, risk pools offer health insurance coverage at somewhat "affordable" prices (i.e., 150% private market) while keeping the number of uninsureds down. High-risk pools ultimately spread the risk over all insurers in the state, thus limiting the adverse selection for any one company.

V. ISSUES TO CONSIDER IN ADOPTING A HIGH-RISK POOL

There are two categories of issues that need to be addressed if a state decides to adopt a high-risk pool. One is the legislative issues and the other is the administrative issues that need to be considered.

Legislative Issues

When adopting a high-risk pool, the state must adopt statutes that govern the pool. A list of some of the main issues that should be addressed in statute are as follows:

- Board of Governors
- Plan Administration
- Rule-making in consultation with the Board
- Plan operation
- Eligibility determination
- Benefit coverage
- Participation of Insurers, Providers etc.
- State subsidies
- Low income subsidies
- Participant premium rates
- Payment of plan costs
- Program budgeting
- Reconciliation of plan costs

The statutes describing the above issues should be detailed, clear and understandable. Since the statutes are the law governing the program, clear concise statutes will make the administration much easier.

After several years, the program may need to be altered to account for the many changing facets of the healthcare system. If any changes are required to the program, it may be necessary to make changes to statutes. The board of governors can be instrumental in recommending any necessary changes to statute and moving them through the legislature before they become law.

Administrative Issues

The administration of a high-risk pool is very important to its success. The state will need to decide which department will be ultimately responsible for running the program. The department will work together with the board in making any changes to the program as well as making decisions on the operation of the plan such as budgeting issues, administrative rules, rate setting, etc. In most situations, the department will need to select a plan administrator to perform the main insurance functions such as premium collection, claim adjudication and other system functions.

The cost of administering the program is included in the total cost to run the program. Administrative costs are combined with operating costs (claims) and are covered by all the funding parties involved. An efficiently run program helps to keep the overall cost of the program down. Some states routinely do a competitive bid with administrators in order to keep the cost down by selecting the lowest bidder.

VI. PROS AND CONS OF HIGH-RISK POOLS

The following is a brief summary of what we believe are the main pros and cons of high-risk pools.

Pros

- Guarantees insurability to all individuals in the state
- Provides "affordable" health insurance coverage to high cost individuals
- Provides better access to quality health care
- Provides stability to the private health insurance market
- Reduces the risk to the private health insurance market
- Spreads the high cost of the program over multiple funding parties

Cons

- Not financially sound if not funded appropriately
- Difficult to balance affordable premiums and affordable insurance assessments
- May require constant political negotiation among participating parties (insurers, state, policyholders, others)
- State may be blamed for rising health care costs
- Requires state to administer a health insurance company

The relative weight of the pros and cons depends on the specific situation in a state and the state's policy objectives. It should be remembered that high-risk pools are designed to provide coverage to the high-risk uninsured, not cover all the uninsured.

The Arizona Statewide Health Care Insurance Task Force has defined six guiding principles to help evaluate the effectiveness of various health care models. The following are some general comments on how the guiding principles are addressed by the high-risk pool concept.

Basic Benefits – Most high-risk pools offer comprehensive coverage. They can be in the form of indemnity type coverage or managed care type coverage which attempt to reduce utilization and manage the individual's care. The benefit coverage will be determined when setting up the program.

Available and Accessible – The eligibility requirements will help determine the availability of the coverage. The stricter the eligibility, the less available the plan

becomes. Accessibility is generally not an issue since the individual can choose the health care provider in either an indemnity type plan or PPO type plan.

Affordable and Properly Financed – Affordability depends on how the program is set up. The program can have a premium cap which limits how high above the industry average the premium can be set. Some high-risk pools have set the premium cap as low as 125% of standard, which is very affordable compared to the risk of the individuals. The other funding parties (e.g., insurers) may view a low premium cap as causing their costs (e.g., assessments) as not being affordable. The more funding parties that are involved, the greater the likelihood that the program will be properly financed. Setting up the funding parties is critical to the success of the program.

Seamless System – Coverage generally appears seamless within the high-risk pool. However, it may not integrate well with employer based or Medicaid coverage due to the differences in benefits and financing.

Collaboration, Cooperation and Competition – High-risk pools will not directly affect competition since the risk-pool premium rates are based on a percentage of the average commercial carrier's rates. Also, they do not lend themselves to collaboration and cooperation in the marketplace since there are usually no private carriers involved.

Public Private Partnerships – High risk pools can usually be considered Public – Private partnerships due to the shared financing and usually shared presence on the Board of Directors.

Appendix B

Summary of Various State High-Risk Pools

California	
Types of Plans	PPO Plan
Benefit Design	$25 co-pay plan 80%/20% coinsurance to max $2,500 for in-network services 70%/30% coinsurance to max $2,500 for out-of-network services $75,000 annual max $750,000 lifetime max
Premium Cap	125% of the "standard average individual rate"
Program Financing	Subscriber premiums State cigarette and tobacco surtax revenue
Program Participants	20,834 as of 12/31/99
Uninsured	7.3 million

Illinois	
Types of Plans	Comprehensive major medical PPO Disabled Medicare Supplement plan
Benefit Design	$500, $1,000, $1,500 and $2,500 Deductibles 80%/20% coinsurance to max of $1,500 (additional out-of-pocket amounts apply when non-PPO hospital providers are used on PPO plans) $1 million lifetime max
Premium Cap	150% of the average rate in the state (125% minimum and 150% maximum)
Program Financing	Subscriber premiums Insurer assessments State appropriation by General Assembly
Program Participants	9,099 as of 6/30/00
Uninsured	1.8 million

Minnesota	
Types of Plans	Comprehensive major medical plan Medicare Supplement plan
Benefit Design	$500, $1,000 and $2,000 deductibles 80%/20% coinsurance to max of $1,000 $2.8 million lifetime max for major medical plan Unlimited lifetime max for Medicare Supplement plan
Premium Cap	125% of weighted average of rates charged by a majority of the insurers and HMO's offering similar coverage
Program Financing	Subscriber Premiums Health insurer assessments in proportion to share of total health insurance premium received in the state during the year Appropriations from various funds including Health Care Access Fund (1.5% tax on hospital and provider charges) and Minnesota's Workers' Compensation Assigned Risk Plan
Program Participants	25,892 as of 6/30/00
Uninsured	0.4 million

Wisconsin	
Types of Plans	Major Medical Plans Disabled Medicare Supplement Plans
Benefit Design	$1,000, $2,500 deductibles for major medical $500 deductible for Medicare Supplement 80%/20% coinsurance to $1,000 for major medical 100% for Medicare Supplement $1 million lifetime max
Premium Cap	200% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductible (150% minimum and 200% maximum)
Program Financing	Subscriber premiums (60% of plan cost after state appropriation) Insurer assessments (20% of plan cost after state appropriation) Provider discounts (20% of plan cost after state appropriation) State appropriation
Program Participants	7,904 as of 12/31/99
Uninsured	0.6 million